Senate

General Assembly

File No. 345

January Session, 2015

Senate Bill No. 6

Senate, April 1, 2015

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (1) of subsection (c) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(1) (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than **[**seventy-two**]** forty-eight hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of

treatments.

(B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

Sec. 2. Subdivision (1) of subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance;

(C) For expedited review requests, except as specified under subparagraph (D) of this subdivision, **[**seventy-two**]** forty-eight hours after the health carrier receives the grievance; and

(D) For expedited review requests of a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, twenty-four hours after the health carrier

receives the grievance.

Sec. 3. Subdivision (1) of subsection (i) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, except as specified under subparagraph (D) of this subdivision, as expeditiously as the covered person's medical condition requires, but not later than **[**seventy-two**]** forty-eight hours after such organization receives the assignment from the commissioner to conduct such review;

(D) For expedited external reviews involving a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as expeditiously as the covered person's medical condition requires, but not later than twenty-four hours after such organization receives the assignment from the commissioner to conduct such review; and

(E) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered

person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2015*	38a-591d(c)(1)
Sec. 2	*October 1, 2015*	38a-591e(d)(1)
Sec. 3	*October 1, 2015*	38a-591g(i)(1)

INS *Joint Favorable*

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill decreases the timeframe from 72 to 48 hours for certain urgent care review requests. This does not result in a fiscal impact to the state employee and retiree health plan and self-insured municipalities because as self-insured entities they are considered an employer and not a carrier for the utilization review procedures outlined in CGS 38a-591d. The bill is not anticipated to result in a fiscal impact to fully insured municipalities.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

SB 6

AN ACT DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.

SUMMARY:

This bill reduces, from 72 to 48 hours, the maximum time by which health carriers (e.g., insurers or HMOs), or independent review organizations, must make a determination regarding certain health benefit reviews of urgent care services or treatment (see BACKGROUND). The bill applies to:

1. initial utilization reviews,
2. internal adverse determination reviews, and
3. external adverse or final adverse determination reviews.

These reviews are part of the process by which a health carrier determines, and an insured may contest, what services and treatments are covered under the insured's policy.

The bill does not apply to urgent care reviews involving substance use disorders and certain mental disorders, which must be completed within 24 hours.

EFFECTIVE DATE: October 1, 2015

HEALTH BENEFIT REVIEW PROCESS TIMEFRAMES

Initial Utilization Reviews

A utilization review is a health carrier's review of a covered person's benefits with respect to a certain medical service. Current law requires health carriers to make determinations on utilization reviews of urgent care requests, as long as the covered person or his or her

authorized representative has provided all the necessary information, as soon as possible but within 72 hours of receiving the request. Under the bill, the maximum time a health carrier may take to make a determination is reduced to 48 hours.

Internal Adverse Determination Reviews

An adverse determination is a decision by a health carrier, following a utilization review, to deny coverage for a specific service based on medical necessity or certain other criteria. At the request of the covered person, the health carrier must internally review the decision. If the review involves an urgent care request, the covered person may, orally or in writing, request an expedited review.

For an expedited review of an adverse determination that was based on medical necessity, current law requires a health carrier to notify a covered person, and if applicable, his or her authorized representative, of its decision within a reasonable period of time appropriate to the covered person's condition, but within 72 hours. The bill reduces the maximum time to 48 hours.

External Adverse or Final Adverse Determination Reviews

Under certain circumstances (e.g. when the internal review process is exhausted or when the request involves an urgent care request), a covered person or his or her authorized representative may request, by writing the insurance commissioner, that an external review of an adverse or final adverse determination be conducted by an independent organization. (A final adverse determination is an adverse determination that has been upheld by the health carrier or after which the health carrier's internal review process is exhausted).

If the request involves urgent care, the covered person or his or her authorized representative may request an expedited external review. Current law requires the independent review organization to notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision in such a case as expeditiously as the covered person's

condition requires, but within 72 hours of receiving the assignment from the commissioner. Under the bill, the maximum time for giving notification of the decision is reduced to 48 hours.

BACKGROUND

Urgent and Nonurgent Care Reviews

By law, a benefit request involves "urgent care" if the time period for non-urgent determinations:

1. could, in the judgment of an individual acting on behalf of a health carrier and applying the judgment of a prudent lay-person who possesses an average knowledge of health and medicine, seriously jeopardize the life or health of the covered person or his or her ability to regain maximum function; or

2. would, in the opinion of a health care professional with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be otherwise adequately managed without the requested treatment or service.

An initial utilization review request may also be determined urgent by a health care professional with knowledge of the covered person's medical condition.

By law, the time period for determining non-urgent care reviews varies based on the type of review or adverse determination review. For example, (1) prospective or concurrent utilization review requests must be determined within 15 days, extendable once for up to 15 additional days and (2) retrospective review requests must be determined within 30 days, extendable once for up to 15 additional days.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 16 Nay 2 (03/17/2015)